Racism and Its Detrimental Effect on the Black Maternal Mortality Rate

The National Library of Medicine reported Black women are 2 to 6 times more likely to die from pregnancy complications than white women. This raises many questions and concerns pertaining to the disparities in health care. Of these obvious disparities in health care, what appears to be the most egregious, requiring the most focus, is the fact Black women are losing their lives due to clear mistreatment. The Black maternal mortality rate is disproportionate because of racist and sexist biases in America that have heavily influenced the American medical field. From the inception of this great nation, to present, the class system of racial definition has been utilized to offer those with white skin, the benefit of greater access. While people of all races band together to attack and address this obvious inequity, this nation and its citizens still suffer from sometimes quite deliberate discrimination, in the form of overt racist and sexist biases. In the medical field, these imbalances in equal treatment impacted by intentional and/or unintentional biases, have influenced and disenfranchised Black women, Black babies, and Black families. The United States is continuously defined as a home of the brave, land of the free, for some. However, the statistics reflect the failure of the constitution and further the continued failure to provide liberty for all.

In America, all citizens are given the promise and belief of access to freedom and the opportunity for success. Americans and those seeking to be a part of this national plan, are told that working hard, educating oneself and staying focused on goal achievement will afford each the opportunity for wealth. Yet, even for those who have reached the pinnacles of success, such as Olympic sprinter Tori Bowie, healthcare disparities remind Black women that the bar for protection and success may not be at the same levels. Bowie, who died at the age of 32 years old, left this world from complications of labor. Considering Bowie was in peak physical condition,

this drew attention to everyone on the imperilment of childbirth for Black women in the United States. The CDC estimated in 2021 that the maternal mortality rate for Black women was 2.6 times that of white women in the US.

Dr. Amanda Williams, Clinical Adviser at the California Maternal Quality Care Collaborative herself, qualified for the 1996 Olympics. Yet, this doctor and top athlete was diagnosed with pre-eclampsia during her first pregnancy. Dr. Williams further explored the cause, offering understanding of the issues in the United States. Dr. Williams spoke of "low risk care," given by midwives is not being given by doctors who are accustomed to higher risk situations.

Reflecting on how some physicians/obstetricians may not allow for many of the natural processes of birth to occur. Williams spoke of lack of access to preventative measures, such as poor access to affordable, healthy choices, leading to poor or challenged nutrition, limited access to appropriate, culturally mindful counseling or labor coaching. The proposal expounded on how socioeconomic and educational backgrounds impact healthcare access. Black women, just like Dr Williams, Tori Bowie, and Serena Williams, have all shared adverse experiences with healthcare. These women, professional, educated, and well versed in communicating symptoms, all shared the similar horrific medical encounters.

The knowledge that Black women have been pushed out of these conversations and spaces, gave birth to the necessity of Black feminist. Bell Hooks emphasized the need for Black women to be represented in white feminist spaces. Also, Kimberle Crenshaw highlighted the imperativeness for black women to be valued and represented as a whole person. Both defining factors fall into marginalized groups, so they cannot be divided to ease others' discomfort. These teachings taught Black women to begin to fight for the right to their own representation.

Furthermore, Black women have further been removed from equitable access to conversations, despite societal platform progress. Black women are constantly being removed from conversations of equality, as society progresses. Too often healthcare providers ignore, belittle, discount and downright distrust Black women's complaints. These concerns are not met with the benefit of the doubt, instead they are met with nothing but doubt. Diagnostic tests are not ordered, symptoms are ignored, misdiagnosed and/or invalidated. Providers view the medical concerns as lacking severity, and when the Black woman becomes angry over being ignored and offered poor treatment, she becomes the 'angry Black woman' stereotype. She is then further demonized, ignored and in some cases even removed by security from the premises, thus removed from the process of respectful participation in the conversation of her own health and wellbeing.

In the state of history, Black women have suffered and continue to suffer institutional abuse. The intersectionality of being a Black woman in the medical system, contributes to the devaluing of the Black mother/fetus dynamic. The interconnected nature and duality of double discriminatory status, within the social categorization of race and gender systems, grossly impact the way Black women are served in the American healthcare infrastructure. The unfair and inequitable treatment has been explored and empirically proven in discussions like that of *Medical Bondage* by Deirdre Cooper Owens, arguments of the nature discuss the revolting use of Black women in advancing medical practices. In the 19th century, Black women were demonized, considered animals, and used to test better practices for White women. With the understanding of the devastations of this American history, on the Black family, Black children, Black mothers, viewed as breeders, children viewed as livestock to be used, traded, sold, bartered. These ideologies continued for centuries of time, and it would be naive and incredibly

obtuse to think these systems do not maintain long term degradation on the psyche of the Black family and on the belief systems of the White Americans. These belief systems continue to encourage discrimination. Some discrimination is present silently, in passive acts of ignoring a patient like the Johnson's cries for help. Some discrimination presents overtly in those who believe in supremacy and therefore birthright of entitlement. Medical entitlement and therefore secondary passive discrimination of providers who subconsciously maintain these beliefs, enacting discriminatory actions in their daily practice.

The mistrust of healthcare providers and healthcare systems stems from this previously mentioned abuse of power and has continued to present day concerns of Black women being treated differently than their White counterparts, based on issues of racial discrimination. How is this still occurring in the 21st century? As they say, history ignored is doomed to repeat itself, yet the knowledge is there. The statistics are there. The women's groups, chats and talks are there. Why is this still impacting women and infants in this day and time? In theory, everyone should be treated equally within the healthcare system especially. However, in practice, this has not been shown to be true. If everyone were being treated equally Black women would not have more than double the mortality rate. The disheartening nature of these statistics may sometimes leave even the most seasoned professional feeling deflated and powerless. The child birthing process is supposed to be a celebration of life yet for Black mothers there are drastically fewer opportunities to celebrate.

So, what is the answer? Are inner cities safer for Black women? Are areas where there are larger Black communities a safer space, or does this translate to less access to teaching equipment, to improved technology? Would it be safer to enter a medical facility that caters to a more affluent area, or would the Black woman be viewed as not belonging and suspicion cast on

her? No. Despite the location of the hospital Black women consistently have a higher maternal mortality rate. There are reports of hospitalization segregation detailing how there was an identified and expressed need for **“**Transparency and desegregation in hospitals are necessary in order to access equal-quality care.” (*American Journal of Obstetrics and Gynecology* 225). Without these parameters strictly enforced Black maternal death is prevalent in all hospitals.

From the heightened blood pressure readings, low birth weights and infant mortality rates, even the impact of issues such as perceived racism, have direct correlations, proven in studies by theologians and medical professionals alike. There have been studies from Dr Rahshida Atkins, RN, Nurse Practitioner, PHD, (PHD Thesis study Perceived Racism and the Impact on the Black Mother/Infant 2013); who reported within one year of African mothers migrating into the US, the infant mortality rate maintained a significant increase in the findings, and maternal health decompensation demonstrated a marked decline; while engaging in the Black American experience. In other sources, one can find cardiomyopathy was 5 times more likely in postpartum Black women than it was for white women in the United States (MacDorman et al., 2021). Showing that the mortality rate of Black mothers is higher and complications after birth are more common. Dr. Williams further made an impactful finding, showing how strong the discriminatory practices are with Black women, who are highly educated and in peak physical condition, yet are still being impacted daily by the cause leading to these statistics.

Cardiovascular-related conditions are among the most common causes of Black mothers' deaths. They argue that these deaths are entirely preventable but require a higher level of care. (American Journal of Public Health 111 (9). However, if Black female experiences and concerns are discounted and invalidated, then preventative deaths will go unprevented. This identifies the

importance of identifying with patients in medical practices. If the doctor sees her sister, her daughter, her family, in the patient, the patient will be more likely to be met with kindness, thorough examination, referrals, resources, and a welcoming bedside manner. Conversely, if the Black mother does not see someone that looks like her, shares her experiences, understands her cultural stressors, with insightful cultural awareness and/or training, the Black mother may be left feeling unheard, troubled, diminished, dismissed. She will be less likely to seek support, to communicate symptoms, to seek specialty care, to go to the doctor early in the pregnancy. Avoidant behaviors present and issues such as cardiovascular stressor may go untreated, resulting in mortality from a treatable condition.

A need to overcompensate in also present for black women in the medical systems, it is a reactive response from being labeled as noncompliant. This fear of the label of being difficult and non-compliant, may cause a Black mother to accept unwanted treatment, to agree on a diagnosis that does not appear to resolve the matter, out of fear of offending the provider and losing the care support. Black mothers are not as free to share feelings of postpartum stressors, depression, and disconnection. Black mothers receive less time consulting with the provider and therefore may forget to mention symptoms, may not know to share them, may feel symptoms are ignored or unrecognized. These medical misses put the Black mother in a higher physiological and psychological risk that may place the mother at risk for higher rates of mortality. These medical mistakes may leave the mother exposed and feeling abandoned; therefore, she may be less likely to seek help when needs arise.

Racist and sexist biases in the medical field have influenced a disproportionate black maternal mortality rate. Therefore, it is the burden that weighs on the medical community; to recognize the existence of healthcare disparities. It is essential for the providers to commit to

addressing these issues, to ensure patients do not suffer due to systemic inequalities. This issue of racial inequality within maternal health care impacts care to patients because it creates a barrier of resistance for patients to seek out the help that they need during their pregnancies. The birth of an infant should be a joyous time. Unfortunately, the joys of childbirth are not shared by all. These joys are not the universal experience for all mothers, especially Black mothers, giving birth in the United States. The U.S. has exorbitant funds that are devoted to healthcare yet, stands as the only developed country to have increased the maternal mortality rates by double, in the past twenty years (Every Mother Counts, 2023). This shocking statistic speaks to the incongruence in healthcare spending and racial inconsistency in service distribution. Additionally, providers must acknowledge the onset, beginning from the horrors of experimental medicine on the enslaved. Experiments such as non-anesthetized sterilizations of Black women, to the Tuskegee syphilis study, allowing syphilis to fester in Black men, as a means of observing the effects of the disease. This refusal to offer medical treatment went on for decades, strengthening the Black community's fear of trusting the medical profession. This issue of racial inequality has a significant impact on patient care. These poor practices lead to delayed interventions, and adverse health outcomes, such as death, for Black patients and Black infants. To prevent these inequalities and to provide proper healthcare for all patients, there are actions that must be taken. Providers can self-reflect and understand their own prejudices, effectively holding themselves accountable. Active listening and addressing all patient concerns, regardless of racial presentation. Peer accountability in which each provider can professionally confront observations of poor care offered. Ultimately, Black women, and people, deserved to be valued and properly cared for, as these deaths are highly avoidable.